

Venereal Disease Control Program In Transition

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Substantial gains continue to be made in reducing the incidence of syphilis in the United States.

Total syphilis morbidity reached an all-time low of 214,000 cases in fiscal year 1951. This is a reduction of nearly two-thirds since 1943.

Admissions to mental institutions for psychoses due to syphilis were reduced by one-half in the decade 1939 to 1949.

Mortality due to syphilis in the period 1937 to 1950 also was reduced by one-half.

Our balance sheet, however, is not all credits. Some items still are entered in red ink: gonorrhea rates continue high—about 280,000 reported cases per year; there is evidence that chancroid is on the upgrade in one or two areas.

But, of considerably more significance, there is evidence that where control activity has been relaxed in this country since World War II, venereal disease rates have remained high. Although these instances are few, they are ominous.

It never has been the policy of the Division of Venereal Disease to cry "wolf!" We do not consider that venereal disease will get out of hand again. On the contrary, we are determined that our control efforts will force a continued decline in morbidity and mortality.

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There is, however, no foreseeable terminus to venereal disease control short of extinction of the disease organisms in this country and abroad. Generally, communicable disease control is based on at least four fundamental operations:

1. Immunization of the population.
2. Isolation of the host.
3. Elimination of the intermediate host.
4. Destruction of the organism.

Only Control Element

In venereal disease control, we have no agent for immunizing the population. If one were available, its use would be questioned and its application costly.

We cannot isolate the host without branding him as a moral delinquent—which (by any standards) frequently is not the case; without finding him—which even now we can do only in about one-half of the cases; and without an infallible diagnostic procedure—which we do not have.

We cannot eliminate the intermediate host, since there is none.

We can destroy the organism, but only after it has announced its presence in the host—an announcement which may or may not be heeded if noted, and an announcement which frequently is never noted.

Thus, our entire control effort is balanced precariously on only one of the four elements in the classic foundation of communicable disease control. With the single exception of treatment, the odds in this struggle are with the spirochete and the gonococcus. Especially is

this true during such a tense period of preparation of our defenses for the potentialities of aggression as the present.

Program Change Indicated

If we are to maintain the gains we have made to date and continue to extend them in the future, certain shifts in program policy and operation seem clearly indicated.

Our program must be shaped to current changes in the character and location of the problem, the movements of the population, and trends in therapy. One device for this orientation of program to problems in venereal disease control is increased project assistance.

These projects make possible the immediate application of Federal, State, and local resources to specific venereal disease control problems within the States and communities, wherever such problems arise and for as long as they exist. Federal project assistance supplements State and local resources and other types of Federal aid which support more permanent activities and do not permit the operational flexibility of project assistance.

Because of the scattered and shifting foci of infection, State and local health departments may not be expected to carry the burden of control and programming alone. These foci often are located in areas extending across State and local boundaries and can be detected only from a searching analysis of data collected throughout the Nation. Activities deriving from these analyses require joint planning and programming by Federal, State, and local agencies, including the military.

Large-scale case-finding projects, as we now know them, could not have been initiated without the rapid treatment center. Their continuation after the centers were established served to exploit to the fullest the service potential of the rapid treatment center projects. So successful was this exploitation that the rapid treatment centers have, over the years, treated hundreds of thousands of infected individuals.

Treatment Methods Changing

During this period, treatment practice has progressed to such a degree that in many areas

continued support of the rapid treatment center cannot be considered economically sound public health administration. For the most part, particularly in urban areas, treatment now may be administered more practically and efficiently in out-patient rather than in in-patient facilities. We are currently in transition between these two methods of treatment, and our control methods must be directed accordingly. I am convinced that the exploration, development, and administration of the most effective transition with the least loss in adequate control will result from project activities. These alone permit the flexibility of plan and operation required in the present transition period.

Interviewing Problem Created

To illustrate the difficulties that are involved in the transition from in-patient to out-patient therapy, consider the problem in interviewing: At the present time, and with notable exceptions, our evaluation reports indicate that the bulk of successful contact investigation is carried on by the States, where the majority of patients go to the rapid treatment centers for therapy. Here they are interviewed, educated, and reinterviewed, with resultant high contact indices and with sufficient care to permit location and examination of their contacts. Transition to the use of out-patient facilities means that interviewing skill no longer can be concentrated in one or a few rapid treatment centers, but must in some manner be made available to both out-patient clinics and private physicians. We may not be able to continue the process, basic to control, of finding and examining contacts of infectious cases when these cases appear in the out-patient clinic and the private physician's office.

In parts of the country which have never had as complete a rapid treatment center system as the South, much work has been done to meet the problem of providing interviewing skill in local areas. Such experience may be of considerable help to us. For example, the North Dakota State Department of Health is planning to use the State highway commission's broadcasting facilities, so that the venereal disease control office at the State capital can keep in constant communication with its two investi-

gators. These investigators work throughout the State in following contacts, suspects, premarital and prenatal cases, and all other persons who, by one means or another, can be benefited by epidemiological aids. Code use of such facilities can preserve the confidentiality of reports.

A group of Middle Western States is developing a program of mutual assistance which will permit interviewer-investigators from border areas and military stations to cross city, county, and State boundaries to carry out their investigations. This will be especially helpful when patients are unable to give the name and address of sex partners but would be willing to accompany an investigator in an effort to locate the contacts.

Expanded use of the telephone and telegraph facilities of the Nation increasingly will be called for as the incidence of venereal disease decreases and the work of venereal disease workers is extended to cover larger geographic areas and an increased number of admitting facilities.

Another program being undertaken by the Division of Venereal Disease is working with medical schools that offer postgraduate training to general practitioners and to specialists. We will arrange for physicians qualified in the field of venereal disease to speak at these postgraduate courses. They can present the latest information on diagnosis, treatment, and the need for providing an opportunity to interview the venereal disease patient to find his contacts. The general practitioners will be informed that this latter service will be made available by the State health authorities to the private physician, whether or not he is officially participating in the State's diagnosis and treatment plan.

It is my belief that interviewing can be improved everywhere. Part of this improvement should come from more effective methods applied in the patient interview. Part of it should derive from an extension of the time period in the patient's life covered by the interview. Still another part should derive from the careful interview of late syphilis and gonorrhea patients whom we have, for the most part, ignored in the past.

Finally, consideration and further study

might be made of the possibility of including in our case-finding activities the investigation of the patients' friends, associates, and accomplices who broadly can be indicated under the term "suspects."

Interviewing and contact tracing require uncommon talents. Not everyone in public health work nor even everyone in venereal disease control work has these talents. Careful training is helpful. At present, we are working on a procedure combining training with self-selection. Mobile sound-monitoring equipment is being assigned to a number of larger local health departments in the country. With this equipment, interviewers may listen to each other in actual interview situations. Those who show exceptional skill and who demonstrate interest in this type of work will be encouraged by health officials in many areas to assume exclusive responsibility for interview-investigation activities.

Interviewing, however, is not the only problem raised by the discontinuance of some rapid treatment centers. Another factor inherent in the transition from in-patient to out-patient treatment applies to those who administer treatment. Physicians, local clinics, and health departments must be re-alerted to look for syphilis and to the best and most modern methods of diagnosis and proper treatment. We are now in the fortunate situation of being able to recruit and assign some of the junior medical members of the Public Health Service's Commissioned Corps to State health departments needing assistance during the defense mobilization period. These officers will be especially helpful in States where the transition from in-patient to out-patient is under way.

Attention has been directed to the problems we are facing and the adjustments we must make to meet them. Two more problems in this field deserve brief comment. One of them pertains to mass blood-testing surveys.

Mass Blood Testing Analyzed

Current analysis of mass blood-testing programs in high-prevalence areas indicates that:

1. They do not find all of the syphilis present in the population.

2. Unless the mass-testing activities are fortified with diligent investigation, they do not prevent the redevelopment of foci of infection.

Reports received from a survey in a large city in 1950 indicate a higher percentage of positive serologic results among a sampling of persons who did not apply for diagnosis during the survey than among those who did. Similarly, figures on syphilis morbidity subsequent to the blood-testing programs carried on in several areas clearly indicate that, in spite of the large numbers of persons tested during the programs, morbidity rates remain relatively high unless proper venereal disease control activity follows the survey.

It would seem, therefore, that mass blood-testing activities should be encouraged only among high-prevalence groups which are carefully pinpointed through the analysis of previous patient admissions, contacts, and suspects. These activities, in themselves, never should be considered to provide complete venereal disease control service.

Gonorrhea Control Important

The other problem relates to need of renewed activity in the mass control of gonorrhea. At the present time the Armed Forces report at least seven cases of gonorrhea for each case of primary or secondary syphilis. Though the treatment of gonorrhea is not a difficult problem in either civilian or military populations, its discovery is just as difficult as that of syphilis, and the finding of the infected sex partner of a

gonorrhea patient involves the same painstaking interview and investigation procedures. Gonorrhea control is important. In the military its treatment wastes the attention and time of medical staffs and it still causes considerable loss of man-days to the defense effort. In terms of syphilis case finding, gonorrhea is a helpful indicator to the remaining and developing foci of venereal infection in the civilian population.

Generally speaking, good progress is being made in the entire field of venereal disease control. However, there is no justification for assuming that, when cases become fewer, control activities have to be lessened. Actually, it now is more difficult to find the few remaining cases than it was when there were many. We should not lose sight of the fact that the reason we control typhoid fever, smallpox, and diphtheria is that considerable effort and money continuously is expended in keeping our water pure and our children immunized. In the field of venereal disease, even when we reach a level at which control can be maintained, we will need to continue to supply a network of services for contact interviewing, tracing, and education in order to prevent a resurgence of the disease. Experience has shown that venereal disease has increased in areas where organized control efforts have been relaxed.

I am happy to report that relaxation of effort is not the mood of venereal disease control officials in the States and communities of this country today. They are requesting and getting the complete support of the Public Health Service in their vigorous follow-through of control activities.

Model Sanitation Regulations Protect 82 Million

More than 82 million Americans live in communities in which public eating and drinking establishments operate under sanitation regulations that meet the standards developed by the Public Health Service, according to a recent survey by the Bureau of State Services. Affected by these regulations are the combined populations of 675 municipalities and 346 counties in 42 States, Alaska, and the District of Columbia.

The bureau stated that this protection has more than doubled in the past 5 years. Only 40 million persons, living in 373 municipalities and 176 counties in 37 States and Alaska, were protected by these sanitation ordinances or regulations in November 1946.